

Bee Caves Dermatology – Patient Information 5656 Bee Caves Rd, Bldg. D, Ste. 203 Austin, Texas 78746
Phone 512-329-6090 Fax 512-329-0125 or E-fax 877-796-4414

Patient Name: _____
(Last) (First) (Middle)

Address: _____
(Street, PO Box, apt #)

(City) (State) (Zip Code)

Home Phone : () _____ Work Phone: () _____

Cell phone: () _____ Email: _____

Date of Birth: _____ DL# & State _____

Sex (Circle): Male / Female Marital status: _____

Insurances Accepted: BCBS PPO, United Healthcare, Medicare Part B (Un-Assigned), Medicare Advantage Plans (Humana, BCBS, we are not in network for all UHC Medicare Advantage plans) Tricare Standard Plan, Scott & White (not all plans), Sendero, Ambetter, Oscar, SANA: Please give your CURRENT insurance card(s) & photo ID to the front desk and fill out the following information.

PRIMARY INSURED / POLICY HOLDER / GUARANTOR INFORMATION:

Name & Relation: _____

Billing Address (if different from above): _____

Phone: _____ Date of Birth: _____

Primary Care Physician: _____

Medical References:

May we leave personal information on your voicemail at home? __Yes __No

On your cell? __Yes __No

May we leave test results with someone other than you, if so with whom?

Preferred Appointment Reminder: __ Phone __ Text __ Email __ None

Preferred Pharmacy & Location: _____

Emergency / Next of Kin Contact:

Name and Relation: _____

Home phone () _____ Work phone () _____

How did you hear about us?

Referring Physician: _____ Internet Search / Website/ Insurance

Friend/Family If yes, please list name _____

ONLY COMPLETE THIS SECTION IF YOUR INSURANCE IS NOT LISTED ON THE FIRST PAGE

Fee for Service Patients Only: Patients with **NO HEALTH INSURANCE** and/or patients with **OTHER HEALTH INSURANCE** that Dr. Martinez is not a contracted provider with, **please read, check & sign below:**

_____ I have no medical insurance.

_____ I have medical insurance with _____ and Bee Caves Dermatology is not a participating provider with this company.

I understand that I will be required to pay in full for services provided to me by Bee Caves Dermatology at the time of service and that no insurance claim will be filed for me by Bee Caves Dermatology. I understand that I will be given a copy of the encounter form, and that I may file my own claim with my insurance company for potential reimbursement / credit for out of network deductibles for medical, non-cosmetic expenses only. I understand that Bee Caves Dermatology can make no estimate or guarantee as to what amount if any my insurance company may reimburse me. I understand that if I choose to supply Bee Caves Dermatology with my insurance information, this information may be entered for me for the purposes of non-cosmetic outside laboratory and pathology fees. However, Bee Caves Dermatology cannot be held responsible for those outside independent charges and cannot guarantee that my insurance company will cover those expenses.

X _____

Privacy Practices Acknowledgement and Receipt

Due to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the following information must be completed and **updated annually** by the patient or guardian:

In the event a family member or caregiver attends my office visits and is in the exam room at the time of my evaluation and/or treatment, I give **Bee Caves Dermatology and employees** my permission to discuss freely my condition, treatment or diagnosis with that person present.

(Circle one) YES NO

Notice of Privacy Practice:

By signing below, I acknowledge that I have been provided a copy of Bee Caves Dermatology's Notice of Privacy Practices Form for review and a personal copy to keep will be provided upon request. Bee Caves Dermatology's Notice is available on the practice's website www.beecavesdermatology.com and a copy can be obtained in office as well.

Signature of Patient or Guardian: _____ Today's Date _____

Relationship to Patient: _____ (i.e., Self, Parent, Legal Guardian)

Personal Health Information (PHI)

This information must be completed and **updated every 6 months** by the patient or guardian

This release authorizes **Bee Caves Dermatology** to discuss medical information regarding my care, condition, treatment or diagnosis with the following:

- Patient Only
- Spouse (Specify Name of Spouse): _____
- Parent(s) (Specify Name of Parent(s): _____
- Other (Please Specify): _____

Signature of Patient or Parent/Guardian: _____ Date: _____

Relationship to Patient: _____ (i.e., Self, Parent, Guardian)

Patient Name: (please print) _____ Date of Birth: _____

Office Policies: Please Read and Initial

Cancellation Notice: Please call and give us the courtesy of 24 hours business day notice for any cancellation. If you fail to give 24-hour notice for cancellation on 2 occasions, (“same day cancellation”) the office will no longer schedule your appointments.

Failure to keep scheduled appointments “No Shows”: If you miss 2 or more appointments without prior notification, the office will no longer schedule your appointments.

Minor patients: A minor must be accompanied by parent or legal guardian, or Bee Caves Dermatology must have written consent to see the unaccompanied minor. **A minor consent form is available on our website, www.beecavesdermatology.com**

Late to appointments: If you are late for an appointment, you may be asked to reschedule or you may be asked to wait to be seen until all other patients that are on time are seen first. If you are late to 3 appointments the office may not schedule you any additional appointments.

Prescription Refills: Please contact your pharmacy to initiate a refill on your prescription. The pharmacy will send a fax with the current prescription information for Dr. Martinez to approve or deny. Regular follow up appointments must be kept to maintain your current medications.

Financial policy for patients with BCBS PPO, United Healthcare, Medicare Advantage Plans, Sendero, Ambetter, Scott & White, Tricare Standard, Oscar, & SANA we will file your claim for you. However, if payment is not received from your insurance company, **you are ultimately responsible for any charges and you will be sent a bill for the charges. Patient statements are sent out monthly. Payment is due when you receive your statement. If no payment is received within 60 days, your account will be automatically turned over to a collection agency. If your insurance company is requesting information from you to process your claim, please contact them immediately to avoid your account being turned over to collections. We do not accept assignment on the Traditional Medicare plan, you will be responsible for the limiting charge at the time of service, we will file to Medicare and any money due back to you will come from Medicare or your secondary/supplement plan.**

Co-Pays and Deductible amounts are due in full at the time of service. Insurance deductibles and co-pays are full responsibility of the patient. Please check with your insurance plan for your personal deductible and surgical deductible amount. Dr. Martinez is a specialist and may have higher co-pays than your primary care doctor.

I have read and understand the above office policies and agree with their terms. I understand that I have provided all appropriate insurance information, if Bee Caves Dermatology is filing my insurance. I understand that I am ultimately responsible for all charges whether paid for by insurance or not.

Signature _____

Date _____

Revised 9/2021 BCD

BEE CAVES DERMATOLOGY --PATIENT MEDICAL INFORMATION FORM

Patient Name: _____
(Last) (First) (Middle)

Male / Female? (Circle one)

Referring Physician: _____

Current or past medical problems: Have you had, or do you have problems with any of the following?

Please circle if yes and explain

If YES, what body part and date

Skin cancer

Basal cell carcinoma

Squamous cell carcinoma

Melanoma

Abnormal moles (that had to be removed?)

Please circle if yes

Cold sores

Hepatitis (A B C) other liver disorder

HIV

High blood pressure

Diabetes

Cholesterol, triglycerides

Kidney disorder

Thyroid disorder

Psychological disorder / depression

Artificial heart valve

Artificial joint

Blood or bleeding disorder

Other cancer _____

Heart

Lungs

Headache / seizure / neurologic disorder

Immune/autoimmune disorder/lupus

Stomach/ bowel/pancreas disorder

Bladder problems

Females - Are you pregnant? Yes / No

Planning to become Pregnant? Yes, when? _____ No

Last menstrual period _____

Skin Cancer Risk

Do you use sunscreen yes / no

Do you use a tanning bed yes / no

Have you had a bad blistering sunburn yes / no

Do you do high sun exposure activities like golfing,

tennis, lake / water sports yes / no

Do you work outside yes / no

Have you been vaccinated for COVID-19?

Yes _____

No _____

Height _____ inches

Weight _____ lbs.

Surgical History: Please list any major surgeries you have had in the past:

Medication Allergies and Reaction:

Current Medications:

Family Medical History: Has anyone in your immediate family had problems with:

Melanoma Yes / No

Nonmelanoma skin cancer Yes/ No

Abnormal moles? Yes/No

Social History: Do you drink alcohol? Yes/ No

Do you smoke/ use other tobacco products? (Dip, snuff) Yes/No

Do you or have you ever used IV drugs? Yes/ No

Sexual History: Are you sexually active? Yes/ No Have you ever had any sexually transmitted disease? Yes/No If yes what type? _____